# Medical Reserve Corps: Strengthening Public Health and Improving Preparedness

LT Marna L. Hoard, MPA, MPH, and CDR Robert J. Tosatto, RPh, MPH, MBA

Across the United States, millions of Americans volunteer their time and efforts to improve the social fabric of their communities. Inevitably, some of these volunteers will be medical and public health professionals. However, because of the complexities of the health field, including concerns about credentialing, training and legal protections, many of these persons have not been able to volunteer in their professional capacities. The terrorist events of 2001 showed that not only would individuals with medical and public health expertise want to volunteer, but that their help could be very much needed in future mass catastrophic events. The Medical Reserve Corps Program was created as a national system of community-based units to promote the local identification, recruitment, training, and activation of volunteers, especially those with medical and public health backgrounds. These Medical Reserve Corps units supplement the existing public health and emergency response entities in the community.

The United States of America has a strong tradition of volunteerism. In all types of communities—large, small, urban, rural, and suburban—millions of Americans volunteer their time and efforts to improve the social fabric of their communities. Inevitably, some of these volunteers will be medical and public health professionals. However, because of the complexities of the health field, including concerns about verifying professional qualifications and providing necessary liability protections, many of these persons have not been able to volunteer in their professional capacities. Physicians, nurses, and other highly skilled health professionals often do provide volunteer services in their communities, but usually not to their fullest professional capabilities.

LT Marna L. Hoard is Program Officer for Outreach, United States Public Health Service, Office of the US Surgeon General, Medical Reserve Corps Program, Rockville, Md. CDR Robert J. Tosatto is Director, United States Public Health Service, Office of the US Surgeon General, Medical Reserve Corps Program, Rockville, Md.

Reprint requests: LT Marna L. Hoard, MPA, MPH, United States Public Health Service, Office of the U.S. Surgeon General, Medical Reserve Corps Program, Rm 18C-14 Parklawn Building, 5600 Fishers Lane, Rockville, MD 20857; E-mail: mhoard@osophs.dhhs.gov.

Disaster Manage Response 2005;3:48-52.

1540-2487/$30.00



doi:10.1016/j.dmr.2005.02.002

## A Need is Identified

The events of September 11, 2001, shocked and surprised the United States. They also brought to light a need for a mechanism to better utilize volunteer medical and public health professionals. Even as the events were unfolding, medical providers began to show up at the scenes. On their own and at tremendous personal risk, these men and women showed up to volunteer their time and expertise to help alleviate the strain on the local medical systems where the terror incidents had happened. They meant well, but unfortunately their appearance at these scenes became problematic for the emergency managers and frustrating for everyone.

The complexities of utilizing these spontaneous, unaffiliated medical and public health volunteers immediately became apparent. Credentialing issues were paramount. For example, how could the licenses and professional qualifications of these volunteers be verified and accounted for when the Emergency Management System had been overloaded and in many cases shut down? The emergency managers were operating in a scenario that some had thought about but few had even begun to plan for. Liability issues were another hot topic. Who would provide the legal protections for these providers, many of whom had come from other areas of the country? And what if the volunteers themselves were injured—how would they be treated or compensated? Finally, who would manage and supervise the volunteers? Emergency management agencies already were spread thin in responding to the events and accounting for their own personnel; they did not have the time or personnel to manage the large influx of volunteers and address such issues as housing and feeding the volunteers and

providing for their safety. The end result was that most of these highly skilled volunteers were turned away and not used.

The anthrax mailings of October 2001, and the subsequent mass medication dispensing responses further highlighted the need for a system of volunteer medical and public health professionals. Federal, state, and local response assets were fully engaged and provided prophylactic doses of antibiotics to thousands of persons who may have been exposed to the anthrax spores. The leaders of these responses quickly realized, however, that they would have been overwhelmed if the population of exposed individuals was much larger. They would need more workers for their "point of distribution" sites, including many more health professionals.

In "lessons learned" sessions and after-action reports from the 9/11 and anthrax responses, the need for a more organized approach to utilizing medical and public health volunteers during catastrophic disasters was discussed. Many of the issues that needed to be addressed were identified, including preidentification, registration, credentialing, training, liability, and activation of these volunteers.

## A Call to Service

In his 2002 State of the Union address, President George W. Bush called upon all Americans to serve their communities through volunteer activities. Furthermore, to demonstrate his commitment to volunteer service, he announced the formation of USA Freedom Corps (*www.usafreedomcorps.gov*), a White House initiative that promotes volunteerism and service throughout the United States. Existing volunteer service organizations, including AmeriCorps, SeniorCorps, and the Peace Corps, were brought under this new initiative, and a new program, Citizen Corps (*www.citizencorps.gov*), was created. Citizen Corps is housed in the Department of Homeland Security and serves as a national network for volunteers dedicated to preparing their families, homes, and communities for terrorism, crime, and disasters of all kinds.

The Medical Reserve Corps (MRC) was officially launched in July 2002 as a specialized component of Citizen Corps. The MRC program (*www.medicalreservecorps.gov*) is housed within the Department of Health and Human Services, in the Office of the Surgeon General. Its mission is to establish community-based teams of local volunteer medical and public health professionals who can contribute their skills and expertise throughout the year as well as during times of community need. The MRC Program Office facilitates the formation and implementation of MRC units by coordinating mechanisms for information sharing and providing forums for discussions of best practices and lessons learned.

The MRC concept is firmly rooted in the needs and issues discovered following the terrorist events of 2001. The MRC provides an approach for organizing medical and public health volunteers and addressing the issues of pre-identification, registration, credentialing, training, liability, and activation of volunteers at the local level.

The MRC program originally was established as a demonstration project to test the validity of this concept of creating cadres of local medical and public health volunteers to help meet the challenges brought on by high-casualty events, as well as those encountered regularly in promoting community public health. Additionally, it tested the ability of local communities to provide training to their volunteers so that they are better able to provide medical and public health services effectively and safely in emergency situations, to organize and activate under accepted command and control structures, and to work collaboratively with other community partners, in particular those within the local community emergency response plan.

All types of communities and organizations ranging from large and urban to small and rural came on board to test the MRC concept. Housing organizations included health departments, boards of health, medical societies, emergency management agencies, nongovernmental organizations, and others. The MRC program has since blossomed to include more than 230 units across the United States, and more than 30,000 individuals, including many medical and public health professionals, have volunteered their services to help strengthen the public health infrastructure in their communities and improve its emergency response capabilities.

## A Resource for the Community

MRC units are not "stand-alone" or first response entities. Instead, they provide personnel to support and supplement the existing emergency and public health agencies in the community. MRC volunteers are a back-up resource for the community during times of great need and also for ongoing public health activities. Community leaders are encouraged to take an all-hazards approach when establishing their MRC unit so that its mission, goals, and organization are tailored to the health needs of their community. Some examples include the following:

- An MRC unit working closely with its community partners identifies a large population of elderly in the community and decides to recruit volunteers with geriatric expertise to provide health services for them.

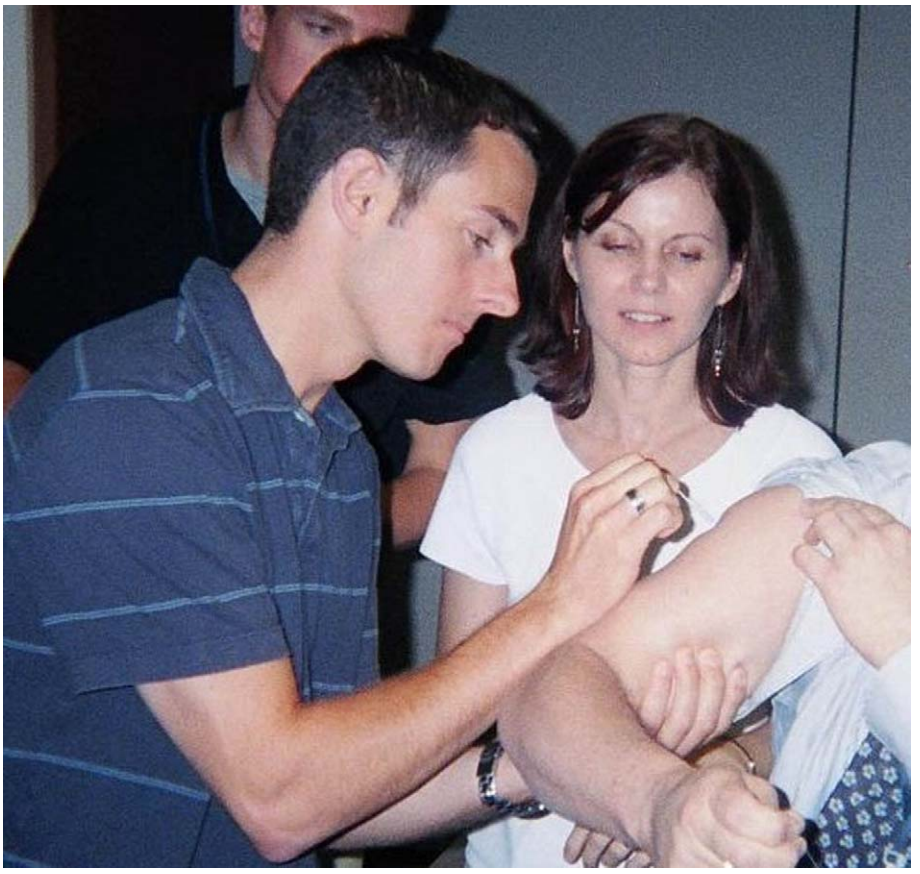

**Figure:** A University of Virginia MRC medical student practicing smallpox immunization at immunization skills station during student disaster medicine training, June 4, 2004, at the University of Virginia School of Medicine, Charlottesville, Va.

- A community with a high likelihood of rabies outbreaks may focus on recruiting veterinarians to serve in the MRC unit.
- An MRC in a community with a large Spanish-speaking population may recruit volunteers with the appropriate language skills.

MRC units across the United States are working to meet and promote the variety of health and safety needs of their communities. Because the MRC program is headquartered within the Office of the Surgeon General, MRC units are encouraged to engage in activities that support the Surgeon General's priorities for public health, which include increasing disease prevention efforts, improving health literacy, eliminating health disparities, and enhancing public health preparedness.

The response of MRC units to the hurricanes that battered the southeastern United States in 2004 highlights the broad range of services the MRCs can provide to their communities during times of emergency. More than 30 MRC units responded in some way to the needs of local communities affected by the storms. MRC members supplemented local hospitals facing critical personnel shortages, supported Red Cross shelters and local special needs shelters, manned first-aid stations, and augmented Federal Emergency Management Agency community outreach efforts. They also supported local evacuation efforts, provided disaster mental health services, and staffed service centers to assist flood victims. Additionally, a local MRC coordinator successfully petitioned Governor Jeb Bush to change the disaster declaration for Hurricane Jeanne to allow out-of-state licensed medical professionals to work under the direction of the Florida Board of Health.

These activities are in addition to the ongoing public health services being provided by the MRC volunteers to their communities throughout the year at events such as immunization clinics, health promotion and disease prevention functions, and policy and planning meetings. Ultimately, MRC volunteers can provide services to supplement the health care provided in their communities that range from clinical care to community outreach to policy analysis.

Because the MRC units take on a variety of activities in their communities, they need volunteers with a broad range of expertise and skill sets (see Figure).

These individuals may be in training, in active practice, or retired. Persons with the appropriate experience and current skills but who are not actively practicing (eg, a physician serving in an administrative position) may be ideal recruits for the MRC because they may not already be expected or counted on to respond in the event of an emergency. Professionals who may volunteer for the MRC include the following:

- Physicians
- Nurses (advanced practice nurses, registered nurses, licensed practical nurses)
- Pharmacists
- Physician Assistants
- Veterinarians
- Dentists
- Mental Health Professionals
- Emergency Medical Technicians and Paramedics
- "Other" medical and public health workers

Although medical and public health professionals can make up the majority of volunteers, the MRC leaders also may decide to recruit persons with no health experience to help with communications, administration, logistics, and other essential functions. Depending on the needs of their community and on their skills and experience, MRC volunteers may be asked to do anything from providing basic first aid at an emergency shelter to providing health education at a community health fair, and everything in between. The MRC is established to help meet the needs of the community; therefore, recruitment and organization of volunteers is conducted in such a way to meet these community needs as well.

## Volunteer Requirements

Because the MRC is a community-based program, the MRC Program Office does not issue directives or mandates that MRC units must follow. Instead, it provides the MRC leaders with guidance based on the best practices and lessons learned from other established MRC units. To a greater extent, MRC leaders are encouraged to interact and communicate with each other to share information directly (for example, using the MRC message board function on the MRC Web site). The requirements for volunteers are set by the local MRC unit, based on the needs of their community. The local unit will also define what is expected of their volunteers regarding training, time commitment, credentials, and a host of other issues. The community-based nature of the program allows the local units the flexibility needed to meet the needs of their communities.

Training is an important issue for all MRC units to consider. Because there are hundreds of training programs focusing on emergency preparedness and disaster response, the MRC leaders should work with their community response partners to decide which training programs are appropriate for their volunteers. In fact, MRC units are encouraged to train with their response partners in order to fully integrate with them. Because most MRC volunteers are medical and public health professionals, it is expected that they will already have a certain level of training and experience within their field. Their training may then focus on issues such as working within the emergency response and public health systems, understanding emergency events, MRC activation procedures, and the National Incident Management System. Of course, each local MRC unit will need to adapt their training accordingly, depending on the expertise and experiences of the volunteers.

Credentialing is another important issue that all MRC units must consider. Credentials are an individual's professional qualifications and can include licensure, education and professional training, board certification or specialization, and hospital privileges. Credentialing is the process of obtaining, verifying, and assessing professional qualifications. At a minimum, all MRC units verify that their members who are licensed health professionals have current, unencumbered licenses. Some MRC units go further and conduct a full credentialing of their members; that is, they verify all of the member's credentials.

The Health Resources and Services Administration, in the US Department of Health and Human Services, has recently instituted a new program called the Emergency System for the Advanced Registration of Volunteer Healthcare Personnel (or ESAR-VHP). Their goal is to establish a national system of state-based registries of medical and public health volunteers. These registries eventually may serve as a mechanism for the states to provide a pre-identification and credentialing service for the MRC units in that state. The MRC units could then be the mechanism to activate and deploy the individuals on the registry. At present, several states are working closely with their local MRC units to develop the collaborative mechanisms necessary to implement a cohesive, coordinated volunteer response.

## Lessons Learned

Because the MRC program is just over 2 years old and is still in the middle of the Demonstration Project phase, it is difficult to define at this time what a good MRC volunteer is, what a model MRC unit looks like, and what works as opposed to what does not work. However, even with this said, it does not take away from the overwhelming progress and impact this program has made in this short time. As mentioned earlier, this program has seen tremendous growth—236 MRC

units have been established in 46 states, the District of Columbia, and the US Virgin Islands. Some of the early lessons learned concern volunteer recruitment, MRC sustainment, and community integration.

Recruitment of volunteers is important, but first the types of volunteers needed in the MRC will have to be determined, again at the local level and in conjunction with the partner organizations. Recruitment should be based on the community's needs for medical, public health, and other types of volunteers. Once the needs are identified, recruiting can take place by putting advertisements on local TV and radio stations, writing stories about the MRC for local newspapers or community newsletters, staffing booths at local health fairs and community events, and sending mass mailings to local medical and public health professionals. For example, the Manalapan Township (New Jersey) MRC held a volunteer recruitment drive at a back-to-school night, and the Fresno (California) MRC partnered with the Community Emergency Response Teams and Volunteers in Police Services Programs to create a "one-stop shop" for interested volunteers.

The MRC allows volunteers to serve a satisfying purpose in their communities and in their professional capacities. Furthermore, it provides a way to keep them engaged, rather than just being names on a list. Many communities have learned that involving volunteers in year-round public health activities not only keeps the volunteers up to date but also keeps them active in the unit, and thus they may be more likely to be available to respond when a disaster strikes.

MRC leaders have found that establishing and maintaining the MRC unit first involves getting organized. Policies and procedures are developed and an organizational structure is put into place. The mechanisms to address the credentialing, training, legal protection, and activation of MRC volunteers also are developed.

Effective leadership by a local MRC director or coordinator is needed; basically, somebody needs to "take ownership" of the unit. New MRC leaders should quickly develop partnerships with other community organizations involved in public health and emergency response because these relationships are a key to the success of the MRC. A strong community network with response partners, government officials, and even local businesses can help to identify needs, negotiate differences, work out conflicts, and optimize shared resources. In fact, the MRC can help to serve as a bridge between many of these groups and persons who often do not talk to each other.

One particular type of partnership that highlights the spirit of community collaboration is the relationship between universities and their local communities. Presently, 8 MRC units are either housed in or partnered with a school of public health, school of nursing, or school of medicine. Students in these programs are learning early on that successful public health and emergency preparedness activities in the community come from the involvement of all the community partners. Teaching this lesson early allows the community to "train up" its next generation of public health and emergency managers, who will then in turn work collaboratively to respond to the public health challenges of the future.

To help MRC leaders with the process of planning, developing, establishing, and sustaining an MRC unit in their community, the MRC Program Office offers the MRC Technical Assistance Series (an action steps-oriented guide), information on lessons learned and promising practices, and other pertinent resources on the MRC Web site. MRC leaders and other persons interested in the MRC program also are encouraged to contact the MRC Program Office by E-mail (*MRCcontact@osophs.dhhs.gov*) or phone (301-443-4951) or to contact existing MRC units for expert advice and information.

Local MRC units are providing a host of services to their communities, and these units give their members an opportunity to be proactive in making their communities safer and healthier. A well-known statement says that "all disasters are local." In the event of a large-scale disaster, local communities will have to rely on their own resources until state and federal help can arrive. A local MRC unit can help the community by having pre-identified and trained volunteers ready to supplement and support the overwhelmed local responders.